PRINTED: 02/08/2016
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445292	A. BUILDING _____ B. WING _____	01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH TREE MANOR	240 HOSPITAL LANE, PO BOX 300 JELLICO, TN 37762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey and investigation of complaint #38121 were conducted from 1/25/16 through 1/27/16, at Beech Tree Manor. A deficiency was cited related to complaint #38121 under 42 CFR Part 483, Requirements For Long Term Care Facilities.	F 000	Disclaimer Statement: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of both Federal and State Laws. F157 1. On February 2, 2016, upon readmission to the facility, Resident #32's spouse was notified that Resident #32 was touched by a confused female resident in a sexual manner on January 1, 2016. 2. Any resident involved in a resident to resident altercation of any sort has the potential to be affected by this deficient practice. To identify other residents who may have been affected, Incident reports and nursing documentation is being reviewed for all residents. Staff involved have been counseled and re-educated on an individual basis. 3. A Resident to Resident Altercation Report (copy attached) has been created that must be completed for any resident to resident altercations. This report triggers the front line staff to notify the resident's responsible party and it also includes a checklist for the Nursing Supervisor to verify that resident's responsible party has been notified. The Staff Nurse, Unit Supervisor, Director of Nursing, Administrator, and Medical Director will review and sign off on this report. Licensed nursing staff will	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		3-9-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles W. Wheeler, LNHA — TITLE: Administrator — (X6) DATE: 3-3-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, and interview, the facility failed to notify a family member of an incident for 1 resident (#29) of 8 residents reviewed for abuse. The findings included: Medical record review revealed Resident #32 was admitted to the facility on 6/2/15 with diagnoses including Alzheimer's Disease, Urinary Tract Infection, Dementia without Behavioral Disturbances, Pain, Atherosclerotic Heart Disease (ASHD), Gastro-Esophageal Reflux Disease (GERD), Hypertension, and Major Depressive Disorder. Medical record review of a quarterly Minimum Data Set (MDS) dated 12/10/15 revealed the Resident #32 scored a 3 on the Brief Interview for Mental Status (BIMS), indicating the resident was severely cognitively impaired, and required extensive assistance with activities of daily living. Medical record review revealed Resident #29 was admitted to the facility on 11/16/15 with diagnoses including Muscle Weakness, Dysphagia, Vascular Dementia with Behavioral Disturbances, Parkinson's Disease, Hypertension, Atrial Fibrillation, Acute Kidney Failure, Alcohol Abuse and Generalized Anxiety. The resident was discharged from the facility on 1/15/16 to a Gero-Psychiatric Unit.	F 157	be in-serviced regarding the Resident to Resident Altercation Report during training on February 19, 2016. 4. The Director of Nursing or designee will review every Resident to Resident Altercation Report the business morning following the incident. The Director of Nursing and Administrator are ultimately responsible for ensuring overall compliance. Resident to Resident Altercation Reports will be reviewed in the monthly Quality Assurance Performance Improvement (QAPI) Committee Meeting.	

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F 157	Continued From page 2 Medical record review of an admission MDS dated 11/24/15 revealed the Resident #29 scored a 3 on the BIMS, indicating the resident was severely cognitively impaired, and required limited assistance with activities of daily living. Medical record review of a Nurse's Note for Resident #32 dated 1/1/16 at 11:44 AM, revealed "...resident in another male resident's room, touching a male resident in an inappropriate sexual manner...redirected to her room by another staff member..." Review of a facility investigation witness statement dated 1/5/16, written by the Staff Development Coordinator, revealed "...on 1/4/16 the [Certified Nurse Assistant - CNA] came into my office after her shift was over and was asking questions...During this time the Activity Director was in my office discussing her upcoming schedule and helping answer [CNA] questions...she proceeded to ask with concern what we were doing about [Resident #32], I asked her to clarify...she stated, [Resident #32] has been exhibiting sexually inappropriate behaviors during the weekend shift...the DON [Director of Nursing] was notified of these behaviors as well as [Assistant Director of Nursing - ADON] on January 5, 2016..." Review of a facility investigation revealed the DON was notified on 1/5/16 regarding Resident #32's inappropriate sexual behaviors which had occurred over the weekend. Further review revealed an investigation was started at the time the DON was notified and the Administrator was notified. Interview with the DON on 1/26/16 at 2:30 PM, in	F 157		

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F 157	Continued From page 3 the DON's office, revealed the DON was made aware of the incident on 1/5/16. Further interview revealed "...the staff had documented on 1/1/16 [Resident #32] had inappropriately touched a male resident [Resident #29] in the groin area...the documentation revealed the residents were separated..." Further interview revealed "...the CNA told [named staff] about the incident on 1/4/16 and I was told on 1/5/16...an investigation was implemented immediately..." Further interview revealed "...the investigation revealed both residents were cognitively impaired..." Further interview confirmed Resident #29's family was not notified of the incident when the incident occurred or after the investigation was completed.	F 157		